Michigan Department of Community Health
Early Hearing Detection and Intervention Program (MDCH/EHDI)
Audiological/Medical Follow-up Services Report

Child's Last Name: _____ Last Name at Birth: _____

First Name: _____ Birth Date: _____ Sample #: _____

Hospital of Birth: _____ ☐ Male ☐ Female Twin: ☐ A ☐ B

Parent's Last Name: _____ First Name: _____ SS#: _____

Address: _____ Phone: (_____) _____

City: _____ State: _____ ZIP: _____

Screening Results

Date: _____

Type of Screen: ☐ AABR ☐ DPOAE ☐ TEOAE ☐ ABR

Risk factor(s) for hearing loss? ☐ Yes ☐ No ☐ Unknown

Referral to audiological diagnostic? ☐ Yes ☐ No

Results: RE ☐ Pass ☐ Fail/Refer
LE ☐ Pass ☐ Fail/Refer

Date audiological evaluation scheduled: _____

Diagnostic Audiological Results

DATE: _____

Type of Test: ☐ OAE ☐ Immittance
☐ ABR-click ☐ ABR-toneburst ☐ ABR-bone

Special Care/NICU? ☐ Yes ☐ No

Risk factor(s) for HL? ☐ Yes ☐ No ☐ Unknown

Acquired HL? ☐ Yes ☐ No ☐ Unknown

Etiology (if known): _____

Results:

RE	LE	
☐	☐	Within Normal Limits
☐	☐	Sensorineural (SN)
☐	☐	Undetermined HL– Sensorineural not ruled out
☐	☐	Conductive (possibly transient), SN ruled out
☐	☐	Conductive (atresia, anotia, etc.), SN ruled out
☐	☐	Mixed
☐	☐	Auditory Dys-synchronus
☐	☐	Mild
☐	☐	Moderate
☐	☐	Severe
☐	☐	Profound

Recommendations:

Medical Eval. Ref.	☐ Yes	☐ No	Date: _____
Repeat Hearing Eval.	☐ Yes	☐ No	Date: _____
Early On Referral	☐ Yes	☐ No	Date: _____
CSHCS Referral	☐ Yes	☐ No	Date: _____
Genetic Referral	☐ Yes	☐ No	Date: _____
Hearing Aid Eval.	☐ Yes	☐ No	Date: _____
Sp/Lang. Ref.	☐ Yes	☐ No	Date: _____
Ophthalmology Ref.	☐ Yes	☐ No	Date: _____

Primary Health Provider: _____

Phone: (_____) _____

Referral to the Guide By Your Side (Parent to Parent Home Visitation Program) ☐Yes ☐No (start date 1/05)

I give my permission to release diagnostic audiological/medical evaluation results to my primary care physician and the Michigan Department of Community Health (MDCH) Early Hearing Detection and Intervention (EHDI) Program, The Michigan Department of Education (MDE), *Early On*7Michigan, and Children's Special Health Care Services. Other collaborating MDCH programs also have my permission to assist with coordination of follow-up on behalf of my child. Diagnostic, follow-up, and intervention information can be sent to MDCH from participating agencies. Information will not be shared with unauthorized people or agencies not involved in hearing screening follow-up and/or intervention in conjunction with the MDCH Program.

Signature of Parent/Guardian: _____ Date: _____

Assessment Site Information

Test performed by: _____ Site Name: _____

Phone: (_____) _____ FAX: (_____) _____

Under HIPAA (164.512 (b) THE PUBLIC HEALTH EXCEPTION

-Covered entities may disclose data to Public Health Authorities for use in public health activities.
-Covered entities that are also Public Health Authorities may use data for public health activities.
-Authorization from patients is not required for these uses and disclosures.

FAX To: (517) 335-8036

Telephone: (517) 335-8884
Mailing Address: MDCH/EHDI P.O. Box 30195
Lansing, MI 48909

Reporting diagnosed hearing loss is mandated under MCLA §333.5721.5805

[Form: DCH-0120/Revised: 11/18/04]